MARYLAND INFANTS AND TODDLERS PROGRAM

Individualized Family Service Plan (IFSP)

Referral Date:	**IFSP Meeting Date:**	**IFSP Meeting Type:** ❑ Interim ❑ Initial ❑ Annual Evaluation

Child and Family Information

Child Name (First/Middle/Last):		
Birth Date:	ID Number:	MA Number:
Address:		Home Phone:
Parent/Guardian/Surrogate Name:		
Address:		Home Phone:
Address:		Work Phone:
E-mail:		Cell Phone:
Best Time to Contact:	Best Method of Contact: ❑ Home Phone ❑ Work Phone ❑ Cell Phone ❑ E-mail	

Team Participant Signatures

Each agency or person who has a direct role in the provision of early intervention services is responsible for assisting the eligible child and family to achieve the outcomes in this IFSP.

Service Coordinator	*Date*	*Evaluator/Assessor* *(or involvement through other means, as appropriate)*		*Date*
Interim/Alternate Service Coordinator	*Date*	*Other Participant*	*Agency/Title*	*Date*
Lead Agency Representative	*Date*	*Other Participant*	*Agency/Title*	*Date*
Parent(s)/Guardian/Surrogate	*Date*	*Other Participant*	*Agency/Title*	*Date*

Service Coordinator Information

If you have questions about this IFSP or any of the individuals working with your child and family, contact your service coordinator.

Service Coordinator Name:	
Agency:	
Address:	
Work Phone:	E-mail:

Projected IFSP Meeting Dates

Projected Date **Six Month IFSP Review**:
Projected Date **Annual IFSP Review Date**:
Projected Date Range **Transition Planning Meeting**:

Child Name:	ID Number:	IFSP Meeting Date:

PART I - INFORMATION ABOUT MY CHILD'S DEVELOPMENT
Section A - Health Information

General Health

What was your child's gestational age at birth? _____ Weeks _____ Days

What was your child's birth weight? _____ Pounds _____ Ounces OR _____ Grams

Who is your primary care physician or other health care professional?	Phone:

IMMUNIZATIONS

Do you have a copy of your child's immunization record? ❑ Yes ❑ No
*If **NO**, please indicate the strategies to be used to obtain a copy of your child's immunization record.*

Does the immunization record have the required immunizations for your child's chronological age? ❑ Yes ❑ No
*If **NO**,* what strategies will be implemented for your child to receive the required immunizations?

Indicate immunizations received (*immunizations in **BOLD** are required for public school):*
❑ **DTaP/DT** ❑ **Polio** ❑ **Hib** ❑ **HepB** ❑ **PCV7** ❑ Rotavirus ❑ MCV4 ❑ Hep A ❑ **MMR** ❑ **Varicella**

Indicate immunizations needed (*immunizations in **BOLD** are required for public school):*
❑ **DTaP/DT** ❑ **Polio** ❑ **Hib** ❑ **HepB** ❑ **PCV7** ❑ Rotavirus ❑ MCV4 ❑ Hep A ❑ **MMR** ❑ **Varicella**

LEAD SCREENING/TESTING

Has your child's lead level been tested? ❑ Yes ❑ No If ***YES***, what was the level? _____
Are there any concerns about your child's lead level? ❑ Yes ❑ No *If **YES**,* please explain. _____
_____

NUTRITION

Are there any concerns about your child's eating, general nutrition or growth? ❑ Yes ❑ No
*If **YES**,* please explain.

GENERAL HEALTH CONCERNS

Is there anything about your child's health (special equipment, allergies, other mental or physical information) that the team should know about to better plan and provide services to your child and family, including specific diagnoses?

Child Name:	ID Number:	IFSP Meeting Date:

PART I - INFORMATION ABOUT MY CHILD'S DEVELOPMENT
Section B - Present Levels of Development

Evaluation Status: ❑ Entry ❑ Interim (Birth to 3) ❑ Exit (Birth to 3) ❑ Interim (Age 3–4) ❑ Exit (Age 3–4)

Present Levels of Development

Area		Date of Assessment (MM/DD/YY)	Name of Assessment Instrument(s)	Chronological Age	Age Level/ Age Range	Qualitative Description
Cognitive	**Cognitive** (Playing, thinking and exploring)					
Communication	**Communication** (Understanding others and expressing myself)					
Social or Emotional	**Social or Emotional** (Emotions, feelings, and interacting with others)					
Adaptive	**Adaptive** (Eating, drinking, toileting, and doing things for myself)					
Physical	**Fine Motor** (Using my hands for play, feeding or other activity)					
	Gross Motor (Moving my body to change position or location)					
	Hearing	Did your child pass a Universal Newborn Hearing Screening? ❑ Yes ❑ No ❑ Not Applicable Has your child seen an audiologist for a full hearing evaluation? ❑ Yes ❑ No Are there any concerns about your child's hearing? ❑ Yes ❑ No Results of Evaluation/Observation:				
	Vision	Has your child's vision been tested? ❑ Yes ❑ No Are there any concerns about your child's vision? ❑ Yes ❑ No Results of Evaluation/Observation:				

Child Name:	ID Number:	IFSP Meeting Date:

PART I - INFORMATION ABOUT MY CHILD'S DEVELOPMENT
Section C - Eligibility for Early Intervention Services

Eligibility

Your child is eligible for early intervention services based upon the results of the evaluation process. Eligibility is based on the ONE category that is checked below.

❑ AT LEAST A 25% DEVELOPMENTAL DELAY

My child is eligible for early intervention services because my child is experiencing at least a 25% delay in one or more of the following developmental areas. **Check all that apply**:

❑ Cognitive ❑ Communication ❑ Social or Emotional ❑ Adaptive ❑ Physical: ___ Fine Motor ___Gross Motor

❑ ATYPICAL DEVELOPMENT OR BEHAVIOR

My child is eligible for early intervention services because my child is demonstrating atypical development or behavior in one or more of the following developmental areas, that is likely to result in a subsequent delay. **Check all that apply**:

❑ Cognitive ❑ Communication ❑ Social or Emotional ❑ Adaptive ❑ Physical: ___ Fine Motor ___Gross Motor

❑ DIAGNOSED PHYSICAL OR MENTAL CONDITION WITH A HIGH PROBABILITY OF DEVELOPMENTAL DELAY

My child is eligible for early intervention services because my child has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. This list is not all-inclusive. **Check all that apply**:

❑ Chromosomal disorder: ___ Down Syndrome ___ Other: _____
❑ Chronic lung disease (CLD)
❑ Congenital infection that is symptomatic (e.g., HIV)
❑ Inborn errors of metabolism associated with CNS involvement (e.g., maple syrup urine disease and galactosemia)
❑ Infants showing significant effects of maternal prenatal alcohol abuse (e.g., Fetal Alcohol Syndrome)
❑ Infants affected by intrauterine drug exposure requiring treatment or showing evidence of intrauterine growth restriction
❑ Intraventricular hemorrhage - Grades III or IV
❑ Lead poisoning, with a lead level of 20 ug/dL or greater
❑ Moderate to severe encephalopathy resulting from insult to the brain
❑ Neurodegenerative disorders with onset in infancy and early childhood (e.g., adrenoleukodystrophy, TaySachs disease)
❑ Periventricular Leukomalacia (PVL)
❑ Prematurity with birth weight of less than 1200 grams (2 lbs. 10 oz.)
❑ Seizure disorder where seizures are frequent or difficult to control or the underlying condition is associated with frequent cognitive impairment (e.g., infantile spasms)
❑ Sensory impairments
  - ☐ Blind or visually impaired
  - ☐ Deaf or hard of hearing
❑ Severe congenital malformations (e.g., meningomyelocele and congenital hydrocephalus)
❑ Surgical Necrotizing Enterocolitis (NEC)

❑ Other: _____

❑ Other: _____

❑ Other: _____

Child Name:	ID Number:	IFSP Meeting Date:

PART II - INFORMATION ABOUT MY FAMILY
Section A - Concerns, Priorities, and Resources

Concerns, Priorities, and Resources

To best support your child and family, it is helpful to know about issues and concerns that are important to your family. Your family's concerns, priorities, and resources will be used as the basis for developing outcomes and identifying strategies and activities to address the needs of your child and family. You may share as much or as little information as you choose.

MY FAMILY'S CONCERNS	MY FAMILY'S PRIORITIES	MY FAMILY'S RESOURCES
Concerns I have about my child's health and development. Information, resources, supports I need or want for my child and/or family.	My hopes and dreams for my child. The most important things for my child and/or family right now.	Resources that my child/family has for support, including people, activities, programs/organizations.

❒ This information was gathered through a family-directed assessment using the following. **Check all that apply**:

- ❒ Locally developed family interview tool
- ❒ Routines-Based Interview (RBI)
- ❒ Ages and Stages Questionnaire (ASQ)
- ❒ Other tools/methods: _____

❒ Family declined family-directed assessment.

Child Name:	ID Number:	IFSP Meeting Date:

PART II - INFORMATION ABOUT MY FAMILY
Section B - Natural Environments

Routines In Natural Environments

Early intervention services are provided in natural environments. A natural environment is a location where your child and family spend time, such as in the home, child care program, or other community setting. Natural environments are where typically developing children play and learn. The information below will help us determine the natural environment(s) in which your child and family will receive early intervention services.

Where does your child/family spend time? Check all that apply:

❑ Child's home	❑ Early Head Start/Head Start	❑ Family Support Center
❑ Child care center	❑ Library	❑ Parent's place of employment
❑ Religious setting	❑ Home of family member	❑ Shelter
❑ Family child care	❑ Toddler playgroup	❑ Other: _____
	❑ Judy Center	

What are some of the activities that you like to do together as a family?

Is there something you would like to do as a family, but cannot do at this time?

What are the daily routines of your child and family? Are some of these routines challenging? Are there other routines that your family would like to establish?

What are the barriers that keep your child and family from participating in your daily routines and activities?

How can the program best support your family in its desire to improve or create important routines?

Child Name:	ID Number:	IFSP Meeting Date:

PART III - MY CHILD/FAMILY OUTCOMES RELATED TO MY CHILD'S DEVELOPMENT
Section A - Strengths and Needs Summary

Strengths and Needs Summary

For children to be active and successful participants at home, in the community, and in places like child care or preschool programs, they need to develop skills in three functional areas: (1) developing positive social-emotional skills; (2) acquiring and using knowledge and skills; and (3) taking appropriate action to meet needs. We use information about your child's present levels of development, your family's concerns, resources and priorities, and your daily routines to understand your child's individual progress in relation to him/herself and to same age peers. This information supports the development of meaningful outcomes for your child and family.

HOW DOES MY CHILD...		MY CHILD'S STRENGTHS What are some things my child likes to do? What skills does my child demonstrate or is beginning to demonstrate?	MY CHILD'S NEEDS What are some skills or behaviors that my child does not do or are difficult for my child? In what activities or skill areas does my child need considerable support and/or practice?	HOW DOES MY CHILD'S DEVELOPMENT RELATE TO HIS/HER SAME-AGE PEERS?
DEVELOPING POSITIVE SOCIAL-EMOTIONAL SKILLS	• Attend to people? • Relate with family members? • Relate with other adults? • Relate with other children? • Display emotions? • Respond to touch?			Has my child shown any new skills or behaviors related to positive social-emotional development since the last *Strengths and Needs Summary?* ❑ Yes (include as "Strengths") ❑ No ❒ Not applicable
ACQUIRING AND USING KNOWLEDGE AND SKILLS	• Understand and respond to directions and/or requests from others? • Think, remember, reason and problem solve? • Interact with books, pictures, and print? • Understand basic concepts such as "more", "big", "hot"?			Has my child shown any new skills or behaviors related to acquiring and using knowledge and skills since the last *Strengths and Needs Summary?* ❑ Yes (include as "Strengths") ❑ No ❒ Not applicable
TAKING APPROPRIATE ACTION TO MEET NEEDS	• Take care of his/her basic needs, such as feeding and dressing? • Move his/her body from place to place? • Use his/her hands to play with toys and use crayons? • Communicate wants and needs? • Contribute to his/her own health & safety?			Has my child shown any new skills or behaviors related to taking actions to meet needs since the last *Strengths and Needs Summary?* ❑ Yes (include as "Strengths") ❑ No ❒ Not applicable
OTHER				

Child Name:	ID Number:	IFSP Meeting Date:

PART III - MY CHILD/FAMILY OUTCOMES RELATED TO MY CHILD'S DEVELOPMENT
Section B - Child and Family Outcomes

Child and Family Outcomes

Based upon information from your child's present levels of development and shared reports, your child's strengths and needs, your family's concerns, priorities, and resources, and your daily routines, this plan outlines what we want to accomplish and the specific steps required. Please discuss your priority outcomes for your child and/or family, including specific skills and context. A separate "Child and Family Outcomes" form is completed for each outcome.

OUTCOME	STRATEGIES/ACTIVITIES/LEARNING OPPORTUNITIES	MEASURABLE CRITERIA
What would we like to see happen?	What steps need to be taken to help accomplish the priority outcome?	How will we know when the outcome is achieved?

TRANSITION OUTCOME	❒ Yes ❒ No
EDUCATIONAL OUTCOMES ADDRESSED (at age 3 or older)	❒ Language ❒ Numeracy ❒ Pre-literacy
TIMELINE	

PARTICIPANTS - *Who will be involved?*

Name:	Title:	Phone/E-mail:
Name:	Title:	Phone/E-mail:
Name:	Title:	Phone/E-mail:
Name:	Title:	Phone/E-mail:

OUTCOME PROGRESS REVIEW

Review Codes: *Select the code that best applies.* 1- Proficient - *We did it!* 2- In process - *We're making progress.* 3- Needs development - *Let's make adjustments.* 4- No longer needed 5- Postponed	**Code:**	**Date:**	**Initials:**	**Comments:**

OUTCOME PROGRESS RESPONSE - *(ONLY NEEDED FOR PROGRESS REVIEW CODE 3)*

Review Codes: *Select the code that best applies.* 1- Revise outcome 2- Modify strategies/activities 3- Change service 4- Other: _____	**Code:**	**Date:**	**Initials:**	**Comments:**

Child Name:	ID Number:	IFSP Meeting Date:

PART IV - MY CHILD'S EARLY INTERVENTION SERVICES

Early Intervention Services

Early intervention services enhance the development of your child and the capacity of your family to meet the needs of your child. Each early intervention service supports your individual child and family outcomes. A separate "Early Intervention Services" form is completed for each service/support/setting.

TYPE OF SERVICE	METHOD OF SERVICE DELIVERY				SETTING
	Number of Sessions	Frequency	Length	Intensity	
Please specify:	❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ Other: _____	❑ Only ❑ Daily ❑ Weekly ❑ Monthly ❑ Yearly ❑ Quarterly ❑ Semi-Annually	*Number of minutes per session:* ❑ 15 ❑ 30 ❑ 45 ❑ 50 ❑ 60 ❑ 90 ❑ 120 ❑ 180 ❑ 240 ❑ Other: _____	❑ Group ❑ Individual	❑ Home *(Principal residence of child's family or caregivers)* ❑ Community-Based Setting *(Please specify):* _____ ❑ Other *(Please specify):* _____ Justification for Other Setting:
Discussion of Early Intervention Service Delivery: _____					

Type of Service		Community-Based Settings *(Where children without disabilities are typically found)*		Other Settings *(Not community or home-based)*
• Audiology • Family Counseling Training • Health • Medical (diagnosis & evaluation only) • Nursing • Nutrition • Occupational Therapy • Physical Therapy	• Psychological • Respite Care • Sign Language/Cued Language • Social Work • Special Instruction • Speech/Language Therapy • Vision Services • Other	• Child care center (including family day care) • Preschool program • Regular nursery school • Early childhood center • Early Head Start/Head Start • Even Start • Judy Center • Library	• Grocery store • Park/Playground • Restaurant • Community/Recreation Center • Parent's place of employment • Shelter • Other	• Early Intervention Center/Class for Children with Disabilities • Service Provider Location (e.g. Outpatient, Audiologist) • Hospital (Inpatient) • Residential facility • Other

Financial Responsibility: Check ***one*** agency responsible for payment of services.
❑ Local School System
❑ Local Health Department
❑ Local Department of Social Service
❑ Other (Please specify): _____

Provider Agency: Record the name of the agency providing the service. Use the standard text designation within each agency.
_____

Reimbursement Source: Check ***one*** reimbursement source *only* when the agency designated as financially responsible intends to request payment for the service from another source.
❑ Medical Assistance
❑ Maryland School for the Blind
❑ Maryland School for the Deaf
❑ Other (Please specify): _____

Provider Name/Phone Number: Record the name and phone number of the individual providing the service.
_____

Projected Service Initiation Date: Record the date on which the service is projected to begin.
_____ MM/DD/YY

Projected Service Review Date: Record the projected date on which the service will be reviewed.
_____ MM/DD/YY

Projected Duration: Record the time period that the service will be provided.
_____ MM/YY

Service Ending Date: Record the date on which the service ends.
_____ MM/DD/YY

Child Name:	ID Number:	IFSP Meeting Date:

PART IV CONTINUED - MY CHILD'S EARLY INTERVENTION SERVICES

Early Intervention Services (continued)

SERVICES FOR CHILDREN WHO ARE BLIND/VISUALLY IMPAIRED OR DEAF/HEARING IMPAIRED

Were parents provided information regarding the Maryland School for the Blind?	❑ Yes	❑ No	❑ N/A
Were parents provided information regarding the Maryland School for the Deaf?	❑ Yes	❑ No	❑ N/A

ASSISTIVE TECHNOLOGY

Does my child need assistive technology services or devices to increase, maintain, or improve his/her functional capabilities? ❑ Yes ❑ No

Types of Assistive Technology Check ***all*** that apply:

- ❑ Activities of Daily Living (ADL)
- ❑ Adaptive Computer Hardware
- ❑ Adaptive Computer Software
- ❑ Auditory Aids
- ❑ Augmentative and Alternative Communication Device (AAC)
- ❑ Environmental Control Units (ECUs)
- ❑ Mobility Aids
- ❑ Play, Recreation, and Leisure Aids
- ❑ Seating and Positioning
- ❑ Transportation/Safety Aids
- ❑ Vision Aids
- ❑ Other _____

Provider

Provider Name:	
Phone:	E-mail:

TRANSPORTATION

Does this plan include the transportation necessary to enable my child and/or family to receive early intervention services? ❑ Yes ❑ No

Types of Transportation

- ❑ Parent with reimbursement
- ❑ School Bus
- ❑ Taxi
- ❑ Public Transportation with reimbursement
- ❑ Other (Please Specify)_____

Is any special equipment needed for transporting my child? ❑ Yes ❑ No

If ***YES,*** specify the type of equipment: _____

Provider

Provider Name:	
Phone:	E-mail:

Child Name:	ID Number:	IFSP Meeting Date:

PART V - SERVICE LINKAGES

Service Linkages

Service linkages are community services and supports designed to enhance your child's development and your family's capacity to meet the needs of your child and family. A separate "Service Linkages" form is completed for each family member.

Service linkages are being provided for the following family member. (Check only *ONE* of the following.)

❑ Eligible Child ❑ Sibling ❑ Family ❑ Parent/Guardian ❑ Other Relative

SERVICE LINKAGES TO BE PROVIDED (Check *ALL* that apply.)

Child Care/Enrichment
- ❑ Before/After Child Care
- ❑ Camps, Day/Residential
- ❑ Early Head Start/ Head Start
- ❑ Even Start
- ❑ Family Day Care
- ❑ Group Child Care Centers
- ❑ In-home Child Care
- ❑ Preschool Program
- ❑ Tutoring
- ❑ Other_____

Income Assistance
- ❑ Emergency Financial Assistance
- ❑ Financial Counseling
- ❑ Food Stamps
- ❑ Public Assistance
- ❑ SSI
- ❑ Other _____

Counseling
- ❑ Adolescent
- ❑ Employment
- ❑ Family
- ❑ Genetic
- ❑ Housing
- ❑ Marital
- ❑ Special
- ❑ Other _____

Medical/Health
- ❑ Assessment
- ❑ Dental Services
- ❑ Diagnostic/Advisory Clinics
- ❑ Equipment/Devices
- ❑ Health Insurance
- ❑ Home Health Care
- ❑ Hospitalization
- ❑ Immunizations
- ❑ Mental Health Services
- ❑ Prenatal Care
- ❑ Prescription Drugs
- ❑ Primary Health Care
- ❑ Screening
- ❑ Substance Abuse Treatment
- ❑ Surgical Procedure
- ❑ Women, Infants, and Children (WIC) Program
- ❑ Other_____

Other
- ❑ Adult Education
- ❑ Child Care Resource Center, Local
- ❑ Family Support Center
- ❑ Family Support Network, Local
- ❑ Family Support Network, State
- ❑ Home Visiting Program (Please specify) _____
- ❑ Housing
- ❑ Judy Center
- ❑ Legal Services
- ❑ Parent Education
- ❑ Project Independence
- ❑ Recreation Program
- ❑ Support Group
- ❑ Other_____

SERVICE LINKAGE PROVIDERS

Provider Name:	Provider Name:
Phone/E-mail:	Phone/E-mail:
Provider Name:	Provider Name:
Phone/E-mail:	Phone/E-mail:

STRATEGIES TO HELP SECURE SERVICE LINKAGES FOR THE FAMILY

PAYMENT SOURCES (Check all that apply.)
- ❑ Health Maintenance Organization (HMO)
- ❑ Medical Assistance
- ❑ No fee
- ❑ Other Health Insurance
- ❑ Parent: Full Payment
- ❑ Parent: Sliding Fee
- ❑ Other: _____

PERSON(S) INVOLVED TO SECURE SERVICE LINKAGES

Name:	Name:
Title:	Title:
Phone:	Phone:
E-mail	E-mail

Child Name:	ID Number:	IFSP Meeting Date:

PART VI - AUTHORIZATION(S)
Section A – IDEA Consent

Authorization(s)

PARENT/GUARDIAN/SURROGATE CONSENT

- I/We have had the opportunity to participate in the development of this Individualized Family Service Plan (IFSP) and have been provided reasonable notice of the IFSP meeting.
- I/We have been informed of my/our parental rights under this program through receipt of the *Parental Rights: Maryland Procedural Safeguards Notice* and a family handbook about Maryland's early intervention system.
- The early intervention services will be provided as described in the IFSP. I/We understand that the IFSP will be reviewed at least every six (6) months.
- I/We understand that my/our consent is voluntary and that I/we may revoke consent at any time.
- I/We understand the records will not be released without my/our signed and written consent except under the provisions of the Family Education Rights and Privacy Act (FERPA). This law allows the release of early intervention records to participating agencies in the early intervention system.
- I/We understand that the public agency will submit information through a statewide database. This database will be used by the Maryland State Department of Education (MSDE) and other State agencies, as appropriate, to enable funding of programs.
- I/We have been informed of the determination(s) of the IFSP team in my/our native language or other mode of communication.
- This plan reflects the outcomes that are important to my/our child and family.
- I/We understand the plan and parental rights and give permission to implement this IFSP.

_____

Parent(s)/Guardian/Surrogate Signature *Date*

Child Name:	ID Number:	IFSP Meeting Date:

PART VI - AUTHORIZATION(S)
Section B – Medical Assistance (MA) Consent

Authorization(s)

PARENT/GUARDIAN/SURROGATE CONSENT

Parental consent must be obtained before the provider agency discloses, for billing purposes, their child's personally identifiable information to the Maryland Department of Health and Mental Hygiene (DHMH), the State agency responsible for the administration of the Medical Assistance (MA) Program, consistent with the Family Educational Rights and Privacy Act (FERPA) and the Individuals with Disabilities Education Act (IDEA). By providing consent, you understand and agree in writing that the public agency may access your child's Medicaid to pay for services provided to your child.

In order to provide early intervention services to your child, the provider agency may not:

- Require you to sign up for *or* enroll in the State's MA Program in order for your child to receive services under IDEA;
- Require you to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services;
- Use your child's benefits under Medical Assistance if that use would:
  - Decrease available lifetime coverage or any other insured benefit,
  - Result in your family paying for services that would otherwise be covered by Medical Assistance and that are required for your child outside of the time your child is in school,
  - Increase premiums or lead to the discontinuation of benefits or insurances, or
  - Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.

You have the right to withdraw your consent to disclosure of personally identifiable information to State's Medical Assistance Program at any time. If you withdraw consent for the provider agency to disclose your child's personally identifiable information it does not relieve the provider agency of its responsibility to ensure that all required services are provided to your child at no cost to parent.

Is the child eligible for MA? ❑ Yes ❑ No **MA Number** _____

- I agree to Early Intervention Services Case Management and that the Service Coordinator(s) identified on this IFSP may be appointed as MA Service Coordinator(s) (COMAR 10.09.40). I understand that I am free to choose an MA Service Coordinator for my child. At this time, I accept the following Service Coordinator(s):

  MA Service Coordinator Name _____

  MA Service Coordinator Name _____

- I understand that if I wish to change the MA Service Coordinator in the future, I can call the early intervention program to make a change.
- I understand that the purpose of this service is to assist in gaining access to needed medical, social, educational, and other services.
- I give my consent for the provider agency to disclose my child's personally identifiable information to the State's Medical Assistance Program in order to access Medical Assistance Benefits.
- I give permission to the provider agency to recover costs from Medicaid for service coordination, as well as health-related services, related to the implementation of my child's IFSP goals.
- I understand that if I refuse to allow the provider agency access to MA funds, it does not relieve the provider agency of its responsibility to ensure that all required services are provided to my child at no cost to parent.
- I understand that this service does not restrict or otherwise affect my child's eligibility for other MA benefits. I also understand that my child may not receive a similar type of case management under MA if he/she qualifies for more than one type.

_____

Parent(s)/Guardian/Surrogate Signature ***Date***

Child Name:	ID Number:	IFSP Meeting Date:

PART VII - MY CHILD'S TRANSITION INFORMATION
Section A - Transition At Age Three

Transition *At Age 3*

TRANSITION PLANNING MEETING DATE	

EXPLANATION FOR MEETING DELAY

If the Transition Planning Meeting is **held after the child has reached 33 months of age**, check the response below that provides an explanation. *(Check only one.)*

- ❑ Attempts to contact family were unsuccessful.
- ❑ Child was referred at *31.5* months of age or later.
- ❑ Family requested to reschedule or delay the meeting.
- ❑ Other: _____

If the Transition Planning Meeting **was not held at all prior to the child's third birthday**, check the response below that provides an explanation. *(Check only one.)*

- ❑ Attempts to contact family were unsuccessful.
- ❑ Child was referred at *34.5* months of age or later.
- ❑ Family declined to participate in the meeting.
- ❑ Other: _____

CONSIDERATION OF ELIGIBILITY FOR PRESCHOOL SPECIAL EDUCATION AND RELATED SERVICES (PART B)

❑ Parents wish to consider Part B eligibility. **❑ Parents DO NOT wish to consider Part B eligibility.**

COMMUNITY SERVICES

Is the family being referred to community services? ❑ Yes ❑ No **If *YES,* check the services that apply.**

Developmental/Medical/Health:

- ❑ Developmental Therapies (other than Part C and Part B)
- ❑ Equipment/Devices
- ❑ Home Health Care
- ❑ Immunizations
- ❑ Mental Health Services
- ❑ Primary Health Care
- ❑ Women, Infants, and Children (WIC) Program

Child Care/Enrichment

- ❑ Camps
- ❑ Family Day Care
- ❑ Group Child Care
- ❑ Head Start
- ❑ Even Start
- ❑ Play Group
- ❑ Preschool Program:
  - __ Public
  - __ Private
- ❑ Recreation Program
- ❑ Judy Center
- ❑ Home Instruction for Parents of Preschool Youngsters (HIPPY)

Family Support

- ❑ Family Support Center
- ❑ Home Visiting Program (Please specify) _____
- ❑ Parent Education
- ❑ Support Group
- ❑ Other: _____

Other Community Services:

_____

_____

_____

TRANSITION PLANNING MEETING NOTES/FUTURE STEPS

Activities	Timelines	Person(s) Responsible

RESULTS OF THE INITIAL IEP ELIGIBILITY DETERMINATION MEETING *(TO BE COMPLETED BY SPECIAL EDUCATION STAFF)*

SPECIAL EDUCATION STAFF: Complete this section and submit to Part C Data Entry **immediately following** the initial IEP eligibility determination meeting. *Check the statement that indicates results of the initial IEP eligibility determination meeting.*

- ❑ The child is determined to be **ELIGIBLE** for ongoing services through an IFSP *or* preschool special education and related services through an IEP.
- ❑ The child is determined to be **INELIGIBLE** for ongoing services through an IFSP *or* preschool special education and related services through an IEP.

Child Name:	ID Number:	IFSP Meeting Date:

PART VII - MY CHILD'S TRANSITION INFORMATION
Section B - Transition After Age Three

Transition *After Age 3*

TRANSITION PLANNING MEETING DATE	

EXPLANATION FOR TRANSITION PLANNING MEETING DELAY

If the transition planning meeting is held **later than 90 days prior to when the child is no longer eligible**, check the response below that provides an explanation. ***(Check only one.)***

- ❑ Attempts to contact family were unsuccessful
- ❑ Family requested to reschedule or delay the meeting
- ❑ Other: _____

If the transition planning meeting **was not held at all prior to when the child was no longer eligible,** check the response below that provides an explanation. ***(Check only one.)***

- ❑ Attempts to contact family were unsuccessful
- ❑ Family chose IEP services prior to 90-day timeline
- ❑ Family declined to participate in the meeting
- ❑ Other: _____

CONSIDERATION OF SPECIAL EDUCATION AND RELATED SERVICES (PART B)

Prior to the beginning of the school year following the child's 4th birthday:

- ❑ Parents wish to consider preschool special education and related services through an IEP.
- ❑ Parents **do not** wish to consider preschool special education and related services through an IEP.

At the beginning of the school year following the child's 4th birthday:

- ❑ Parents wish to consider preschool special education and related services through an IEP.
- ❑ Parents **do not** wish to consider preschool special education and related services through an IEP

COMMUNITY SERVICES

Is the family being referred to community services? ❑ Yes ❑ No **If *YES,* check the services that apply.**

Developmental/Medical/Health:

- ❑ Developmental Therapies (other than Part C and Part B)
- ❑ Equipment/Devices
- ❑ Home Health Care
- ❑ Immunizations
- ❑ Mental Health Services
- ❑ Primary Health Care
- ❑ Women, Infants, and Children (WIC) Program

Child Care/Enrichment

- ❑ Camps
- ❑ Even Start
- ❑ Family Day Care
- ❑ Group Child Care
- ❑ Head Start
- ❑ Home Instruction for Parents of Preschool Youngsters (HIPPY)
- ❑ Judy Center
- ❑ Play Group
- ❑ Preschool Program:
  - __ Public
  - __ Private
- ❑ Recreation Program

Family Support

- ❑ Family Support Center
- ❑ Home Visiting Program (Please specify) _____
- ❑ Parent Education
- ❑ Support Group
- ❑ Other: _____

Other Community Services:

_____

_____

_____

TRANSITION PLANNING MEETING NOTES/FUTURE STEPS

Activities	Timelines	Person(s) Responsible

Child Name:	ID Number:	IFSP Meeting Date:

PART VIII - PARENT CONSENT (*At or Before Age Three)*
***Family Choice:* Consent to the Continuation or Request Termination of IFSP Services**

Families Have A Choice

- I/We have received a copy of the Annual Notification, "*A Family Guide to Next Steps When Your Child In Early Intervention Turns 3 – Families have a choice*."
- I/We have been informed about the differences between the early intervention services provided through an Individualized Family Service Plan (IFSP) under the Individuals with Disabilities Education Act (IDEA) and the preschool special education services provided through an Individualized Education Program (IEP) under IDEA.
- I/We understand my/our child has a current IFSP and that my/our child has been found eligible for preschool special education as a child with a disability under IDEA.
- I/We have been informed of my/our right to choose between the IFSP Option to continue receiving early intervention services through an IFSP or to initiate special education preschool services through an IEP.
- I/We understand that if I/we choose for my/our child to receive services through an IEP and terminate IFSP services, my/our child and family will no longer be eligible through an IFSP.
- I/We understand that if I/we choose for my/our child to receive services through an IFSP, at any time I/we may terminate participation in early intervention services through an IFSP and choose to initiate special education preschool services through an IEP.
- I/We understand that the local lead agency is required to continue to provide IFSP services under the Extended IFSP Option until the date on which services through an IEP are initiated. However if, I/we choose the IEP option but refuse to consent to the special education and related services offered in the IEP developed by the IEP team, I/we understand IFSP services will be terminated.
- I/We understand that my/our consent to the continuation of IFSP services is voluntary and that I/we may revoke consent at any time.

FAMILY CHOICE

*Check **ONE** box.*

- ❑ I/We consent to the **continuation** of early intervention services for my/our child and family through an IFSP after my/our child's third birthday.
- ❑ I/We request **termination** of early intervention services for my/our child and family through an IFSP at age 3.

_____
Parent(s)/Guardian/Surrogate Signature *Date*

_____
Service Coordinator *Date*

_____
Other Participant *Agency/Title* *Date*

_____
Other Participant *Agency/Title* *Date*

Child Name:	ID Number:	IFSP Meeting Date:

Individualized Family Service Plan (IFSP)
ADD/CHANGE FORM

IFSP Review

CHANGES TO CHILD AND FAMILY INFORMATION

(Changes to demographic information do NOT require a parent signature.)

CHILD INFORMATION:

Child's Name: _____

Address: _____

_____

Phone: _____

Birth Date: _____

Medical Assistance #: _____

FAMILY INFORMATION:

Name: _____

Address: _____

_____

Phone: _____

E-mail: _____

Relationship to Child: _____

SERVICE COORDINATOR INFORMATION:

Name: _____

Agency: _____

Phone: _____

E-mail: _____

REVIEW OF THE IFSP

REVIEW TYPE: *Select* ***one***.

MEETING DATE: _____

- ❏ Six Month
- ❏ Annual Review
- ❏ Provider Request
- ❏ Parent Request
- ❏ Parent/Provider Request

REVIEW STATUS: *Select* **one** *to* ***continue***, ***modify*** *or* ***end*** *the IFSP.*

- ❏ Continue IFSP
- ❏ Modify IFSP: Select ***all*** that apply.
  - ☐ Service Addition
  - ☐ Service Modification
  - ☐ Service Ending
  - ☐ Add/Modify Outcomes
  - ☐ Transition Planning-*At Age 3*
  - ☐ Transition Planning-After Age 3
- ❏ End IFSP: *If selected, complete the* **"REASON FOR INACTIVE STATUS"** *selection below.*

REASON FOR INACTIVE STATUS: Select ***one***.

INACTIVE DATE: _____

- ❏ Attempts to contact were unsuccessful (Birth–Age 4)
- ❏ Completion of IFSP prior to reaching age three (Birth to 3)
- ❏ Deceased (Birth–Age 4)
- ❏ Determined ineligible-*child was never eligible* (Birth to 3)
- ❏ Determined ineligible-*screening only* (Birth to 3)
- ❏ Moved out of State (Birth–Age 4)
- ❏ Moved to another jurisdiction (Birth–Age 4)
  NAME OF JURISDICTION: _____
- ❏ Parent withdrawal (Birth–Age 4)
- ❏ Transition at age three-*not continuing on an IFSP* (Birth to 3)
- ❏ Transition after age three (Age 3–Age 4)
- ❏ Completion of IFSP after age three (Age 3–Age 4)
- ❏ Transition at the beginning of the school year following the 4th birthday

I/We have been provided with reasonable notice of the review of this IFSP. I/We have had the opportunity to participate in the review of this IFSP. I/We have been informed of my/our parental rights through the **PARENTAL RIGHTS: MARYLAND PROCEDURAL SAFEGUARDS NOTICE** and give permission to the early intervention program to implement any IFSP revisions based on this review.

_____

Parent(s)/Guardian/Surrogate Signature *Date*

Service Coordinator *Date*

Other Participant *Agency/Title* *Date*

Other Participant *Agency/Title* *Date*